Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PARKER CITY PHARMACY
1005 E COURT STREET
SEGIN TX 78155

Respondent Name

CONTINENTAL CASUALTY CO

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-05-B822-01

MFDR Date Received

August 22, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary on Table of Disputed Services: "Manufacturer had a price increase which is out of our control. All previous…has been paid."

Requestor's Position Summary dated August 19, 2005: "…I spoke with Theresa Borzik numerous times…Enclosed you will find two copies of everything…"

Requestor's Position Summary dated September 8, 2005: "Parkers' City Pharmacy has sent copies of ALL information to you."

Amount in Dispute: $3,269.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Although the respondent acknowledged receipt of the dispute on September 6, 2005, no position summary was included.

Submitted by: CAN, PO Box 27537, Houston, TX 77227, Theresa Borzik, Claims Consultant

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Ordered
December 27, 2004 and January 24, 2005	Pharmaceuticals	$3,269.65	$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.304, *24 Texas Register 10281*, applicable to dates of service on or after July 15, 2000.

Issues

1. Did the requestor file this medical fee dispute in accordance the applicable rules?
2. Is the requestor entitled to reimbursement?

Findings

1. Applicable 28 TAC §133.307 (e)(2) requires, in pertinent part, that a request for medical fee dispute resolution " …***shall*** [emphasis added] include: (A) a copy of all medical bill(s) as originally submitted to the carrier for reconsideration in accordance with §133.304; (B) a copy of each explanation of benefits (EOB)…or if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB…" Documentation received from the requestor on August 22, 2005 did not contain documentation to support the requirements of §133.307 (e)(2)(A) or (B). Consequently, the Texas Department of Insurance (formerly the Texas Workers' Compensation Commission) made two separate requests for documentation from the Parker City Pharmacy. The first request for a copy of each explanation of benefits was made on June 27, 2005. The second request for documentation to support that the services in dispute were submitted to the carrier for reconsideration was made on August 12, 2005. The requestor in its response submitted medical bills marked "request for reconsideration" in red ink. The requestor in a September 8, 2005 letter to the division stated "Pharmacy has sent copies of ALL information to you."
   - Review of the documentation submitted by the requestor to date finds that although the requestor provided medical bills for the services in dispute, it did not provide documentation to sufficiently support that the medical bills for the services in dispute were submitted to the workers' compensation insurance carrier for reconsideration in accordance with §133.304.
   - Review of the documentation submitted by the requestor to date finds that the requestor did not provide a copy of any explanation of benefits for the services in dispute, nor did it provide convincing evidence of the workers' compensation insurance carrier's receipt of Parker City Pharmacy's request for an EOB.

   The division concludes that the requestor failed to meet the requirements of 28 TAC §133.307.

2. Documentation found does not support that the requestor filed this medical fee dispute in the form and manner required by 28 TAC §133.307. For that reason, no reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		December 28, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.